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MEDICARE AND MEDICAID FRAUD

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

MAY 15, 1980

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MEDICARE AND MEDICAID FRAUD

THURSDAY, MAY 15, 1980

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND LONG TERM CARE,
SELECT COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:00 a.m., in room 2318, Rayburn House Office Building, Hon. Claude Pepper (chairman of the subcommittee) presiding.

Members present: Representatives Pepper of Florida, Bonker of Washington, Ford of Tennessee, Drinan of Massachusetts, Ratchford of Connecticut, Stack of Florida, Abdnor of South Dakota, Marks of Pennsylvania, Hollenbeck of New Jersey and Whittaker of Kansas.

Staff present: Charles H. Edwards III, chief of staff; Val J. Halamandaris, senior counsel; David Holton, chief investigator; Kathy Gardner, professional staff member; Nancy Smythe, investigative researcher; of the Select Committee on Aging. Louise Bracknell, staff director; Mark Covall, research assistant; and Larry Parkinson, minority staff director; of the Subcommittee on Health and Long-Term Care. Mary E. Garver, minority staff assistant; of the Subcommittee on Retirement Income and Employment.

OPENING STATEMENT OF CHAIRMAN CLAUDE PEPPER

Mr. PEPPER. The committee will come to order.

We have important witnesses here so we will begin, if I may.

I would like to welcome you to this hearing by the Subcommittee on Health and Long Term Care of the House Select Committee on Aging. We meet this morning to examine what progress has been made in eliminating fraud and abuse from medicare and medicaid.

Four years ago hearings by this committee, by the House Ways and Means Committee, and by the Senate Aging Committee disclosed widespread fraud in our Government health care programs. It was proven conclusively that a small number of corrupt nursing home owners, physicians, and representatives of clinical laboratories were defrauding taxpayers of millions of dollars.

The much heralded news program, CBS "60 Minutes" managed to film the solicitation of illegal kickbacks and rebates by the 12 clinical laboratories that controlled 90 percent of the medicaid business in the State of Illinois. I think all America was shocked by the graphic disclosures of fraud depicted on national television.

The Congress, which has taken the lead in exposing fraud, then estimated that 10 percent or more of all medicare and medicaid payments were lost in this fashion. We reacted immediately with new laws. One bill created the Office of the Inspector General in the Department of Health, Education, and Welfare.

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A second action authorized 100 percent Federal funding to aid States in the creation of medicaid fraud units. This same legislation increased the penalty for offering, soliciting or receiving illegal medicare/medicaid rebates from a misdemeanor to a felony punishable by a $25,000 fine, 5 years in jail, or both.

One of my amendments to this second bill made it illegal for a nursing home to demand forced contributions from relatives as a precondition of admitting their loved ones to nursing homes.

When President Carter entered the White House he made a firm pledge to eliminate fraud and abuse. He called upon HEW's Inspector General and the Director of the FBI to join forces in this important endeavor. In October 1978, Attorney General Griffin Bell appeared before our committee and told us that several investigations were underway which had already borne fruit at that time. A few weeks ago, the FBI made the first public announcement that they had found widespread fraud in the form of kickbacks between clinical laboratories operating in California and several physicians who specialize in medicare and medicaid patients.

As we begin this hearing to learn more about the FBI's California investigation as well as any others they wish to talk about today, I wish to commend the FBI and their able Director, Judge William Webster, for the fine work that they have been doing in this area. I think the message that I want to send from today's hearing is that we in Congress intend to redouble our efforts to eliminate the fraud and graft which not only cheats the older American of health care services to which he is entitled, but also robs the taxpayer as well.

After we hear from the FBI, I will call upon HEW's Acting Inspector General, Richard Lowe, to learn what progress the Department has made and what more the Congress might do to help.

Before we get to the witnesses, we will call on the committee members for any remarks they may have.

Mr. Bonker.

STATEMENT OF REPRESENTATIVE DON BONKER

Mr. BONKER. Mr. Chairman, I will submit my formal statement for the committee record and would simply commend you for not only this hearing but a series of hearings you have sponsored which gives this committee a chance to look more closely at these abuses. I think it is regretful this committee has to devote so much time to the problem of abuses and corruption in the medicaid and medicare programs. We should be looking conceptually at new programs or making those programs more efficient.

This year we have looked at medicare abuses and at abuses in the sale of health insurance policies to the elderly. Now we have to look at this whole series of abuses in medicare and medicaid and the enormous abuses that are taking place. I think it is a sad commentary on the system that we have to devote this much time to the problem.

Nonetheless, it is important that the moneys we allocate to benefit senior citizens are not being misused by those involved in that system.

I would draw the committee's attention to the Senate report of June 15, 1976, which I have had an opportunity to read. That

report discloses techniques of fraud and abuse in medicaid employed by certain medical laboratories. They were charging medicaid for tests not ordered by the physicians and in some instances laboratories charging medicaid for inappropriate tests for the disease diagnosed by the physician, charging medicaid patients more than other individuals. They were also charging for services not rendered.

Finally, they supplied the physician with free services or equipment or preprinted forms which made it impossible for the physician to order certain lab tests without ordering other tests.

Obviously, a deterioration of quality of service goes hand-in-hand with fraud as the fine report notes.

Once again, Mr. Chairman, I commend you for these hearings.

[The prepared statement of Representative Don Bonker follows:]

PREPARED STATEMENT OF REPRESENTATIVE DON BONKER

Mr. Chairman, it is both a pleasure and a matter of some consternation that we sit as a Subcommittee today. A pleasure because any time that an area of fraud and abuse of public health funds is revealed, we can attend to some long overdue "housekeeping," insure fiscal accountability and improve the quality of service offered to the American public.

It is a matter of consternation because of the pathetic delay to see the results of that housekeeping. The Senate Subcommittee on Long-Term Care received testimony and conducted its investigation four years ago—and yet I understand that kickbacks, payoffs and widespread fraud still plague the Medicare and Medicaid payments to clinical laboratories.

I will be listening with special interest to the testimony of Mr. Lowe, Acting Inspector General of the Department of Health and Human Services, to see what progress his agency has made in combatting fraud in Medicare & Medicaid during the intervening four years.

Mr. PEPPER. Thank you.

Mr. Abdnor.

STATEMENT OF REPRESENTATIVE JAMES ABDNOR

Mr. ABDNOR. I am pleased to be able to participate in today's hearing, although I wish this session was not necessary. It is unfortunate that fraud, waste, and abuse have become such commonplace terms on Capitol Hill.

When Congress passed the Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977, it was our hope that we wouldn't have to keep hearing about millions of lost Federal dollars. In spite of all the talk within the Department of HEW, and in spite of legislative efforts to crack down on fraud and abuse, it is evident that millions, and perhaps billions, of dollars are still being wasted in our medicare and medicaid programs.

It is particularly exasperating to find ourselves in a position this year where we are forced to postpone or cancel desperately needed medicare and medicaid improvements because of inadequate funding. The Aging Committee and the legislative committees have worked for several years to develop a number of medicare and medicaid improvements. At this very moment, many of those proposals are waiting to come to the floor of the House. But because we have allowed millions to be stolen through fraud and abuse, consideration of these measures will probably have to wait until another year. This waste is robbing not only every taxpayer in this country, it is robbing the elderly and poor who need assistance.

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I am pleased that the Inspector General is here this morning because it appears to me that some explaining needs to be done. Several years ago, a major investigation was conducted which exposed many abuses in clinical laboratory operations. In light of such findings, the Department should have made a major effort to stamp out this fraud, which was well documented and apparently quite prevalent. What has the Department done in this area? Why do we need to be here today to hear about more and more abuses?

Abuses in clinical laboratory operations probably represent only a small part of the total waste within the medicare and medicaid programs, but they also represent a deplorable affront to patients and to the medical profession as a whole. We have been told of cases where blood samples and other medical specimens have been poured down the drain in so-called labs, and the patient has been given a medical report which has been completely fabricated. To think that members of the medical community play so recklessly in such life and death matters is nauseating.

I sincerely hope that we will not have to reconvene next year or 2 years later to hear about similar abuses. I commend the FBI for its efforts in this area, and I hope the Inspector General will convince us that the new Department of Health and Human Services is serious about rooting out crime within its own programs.

I look forward to hearing from our witnesses. Thank you.

Mr. PEPPER. Thank you.

Mr. Ford.

STATEMENT OF REPRESENTATIVE HAROLD E. FORD

Mr. FORD. Thank you very much.

I, too, join with my colleagues on the committee today in saying it is unfortunate we have to be here today on this crucial issue and I would like to commend you, Mr. Chairman, for holding these hearings. I join with my colleagues in welcoming the witnesses who will be participating in the hearing today. I am anxious to hear the testimony and I am confident the hearing will bring to light instances of abuse in medical laboratories. I am confident this hearing will be a step forward in determining the additional legislative reforms needed to effectively combat this problem.

Your leadership, Mr. Chairman, today and in the past, exemplifies what this committee and this Congress is all about. Hopefully this will send a clear message to those who have somewhat engaged in some wrongdoing and hopefully, we will provide those services that are needed to those whom the Congress had intentions of providing those services.

Mr. PEPPER. Thank you very much, Mr. Ford.

Mr. Marks.

STATEMENT OF REPRESENTATIVE MARC L. MARKS

Mr. MARKS. Thank you, Mr. Chairman.

I, too, want to congratulate you and if I may, the staff, for the work that they have done in this particular issue, one of great

concern to all of us. I join with you and the other members in looking forward to the testimony we will hear today which hopefully will lead us to be able to do something affirmatively as far as the fraud and abuse is concerned and particularly as far as the concern we all have to the elderly and the poor.

Mr. PEPPER. Thank you very much, Mr. Marks.

Father Drinan.

Mr. DRINAN. I want to congratulate you, Mr. Chairman, for your leadership and the witnesses for their efforts in this area. I have read the statements. Results have already been demonstrated and with the collaboration of the executive branch, I hope we destroy this evil which is so insidious.

I thank you, and yield back the balance of my time.

Mr. PEPPER. Thank you very much.

Mr. Hollenbeck.

Mr. HOLLENBECK. I merely echo the concerns of my colleagues.

Mr. PEPPER. Thank you.

Mr. Ratchford.

STATEMENT OF REPRESENTATIVE WILLIAM R. RATCHFORD

Mr. RATCHFORD. As you know, I chaired a committee in the State of Connecticut authorized to investigate nursing home abuses.

The sad fact is that in the nursing home area throughout the United States, when the spotlight is on the homes, we have corrective action; when it is not they fall back into practices that are despicable and cost the taxpayers millions of dollars.

As to pharmacies, we found each firm had a consultant pharmacy so on the one hand they were consulting, making recommendations to the individual and then turning around and selling to the individual with an obvious conflict of interest.

In addition, in many, many situations, there is over medication. We found the average patient taking five different drugs daily. That is a higher level than a similar person in the community with the same profile.

The only way we can avoid further abuse is through the testimony hearing we are having this morning. I look forward to the testimony, but more significant, if it results in need for legislation, I look forward to working with you, Mr. Chairman, to see to it that that legislation is passed; to see to it that individuals receive the care needed but not more care than the individual needs at a sacrifice to the taxpayer.

Mr. PEPPER. Thank you, Mr. Ratchford. Mr. Stack.

Mr. STACK. I join with my colleagues in commending you for bringing to the public matters which need the attention of Congress, in this case, the question of abuse and fraud in medicare and medicaid. I look forward to the testimony and again commend you for your action in this field.

Mr. PEPPER. Thank you very much, Mr. Stack.

If there are no objections, I would like to submit the written statement of our colleague William Wampler for the record at this time. Hearing no objections, so ordered.

[The prepared statement of Representative William C. Wampler follows:]

PREPARED STATEMENT OF REPRESENTATIVE WILLIAM C. WAMPLER

Mr. Chairman, I am most appreciative of the opportunity to participate in today's Subcommittee on Health and Long Term Care hearing on "Fraud and Abuse Among Clinical Laboratories." I am pleased you have initiated this hearing and welcome the opportunity to discuss the extent of fraud and abuse in clinical laboratories and the effectiveness of recent legislative reforms. I welcome each of the witnesses and look forward to your testimony as your combined expertise will provide the Subcommittee with valuable information and recommendations to curb Medicaid fraud.

I am especially interested in the findings of FBI investigations which indicate that Medicaid kickbacks are paid to some physicians and some clinical laboratories. It is alarming to note that between 20 and 55 percent of the money which Medicaid paid for lab services constitutes Medicaid kickbacks, according to a Senate Special Committee on Aging hearing.

I also look forward to reviewing any recommendations the Office of the Inspector General of the Department of Health and Human Services may have with regard to combatting these recent abuses in Medicaid and Medicare. We also hope to learn if administrative barriers within H.H.S. hamper the investigatory process in any way. Does the Office of the Inspector General have sufficient resources and manpower to enforce the Act?

The Anti-Fraud and Abuse Amendments of 1977 created the Office of the Inspector General within H.H.S. to investigate fraud and abuse in Federal health programs. We hope to obtain specific data on the number of cases pending and closed, as well as the number of active criminal investigations, indictments and convictions. With respect to recoveries, I trust that the Inspector General will reveal the amounts of fines, restitutions and recoveries since enactment.

I am pleased to share the progress that the Commonwealth of Virginia has made with regard to combatting abuses in Medicaid. In July 1978, the Surveillance and Utilization Review Section of the Virginia Medical Assistance Program was established to investigate possible fraud and abuse among providers and recipients of Medicaid and to maintain liaison to welfare agencies. I am pleased to report that since its existence, investigations indicate that compliance with the Virginia state policy is substantial and that no major abuses in Medicaid payments for laboratory fees have occurred. In addition, the Review Section is publishing a new manual for physicians designed to help alleviate misunderstandings in the billing process and outline the federal regulations. It is anticipated that the new manual will be ready within the next several weeks, at which time seminars for physicians will be conducted to explain the procedures.

Mr. Chairman, I trust that the results of today's hearing will be enlightening and that viable recommendations to combat abuses in Medicaid will be considered.

Mr. PEPPER. Before we proceed with the hearing, may I ask for the attention of the members. We had called a business meeting of the subcommittee prior to this hearing this morning, but we only had five members present. We now have nine members present, which is a quorum of the subcommittee. We need a quorum in order to vote on the subpenas we want to issue.

As you know, the GAO, at our request, is conducting an investigation of the conditions in what we call boarding homes in this country. Without objection, I will insert my letter to the GAO dated July 9, 1979, regarding this investigation into the record at this point.

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, D.C., July 9, 1979.

Hon. ELMER STAATS,
Comptroller General of the United States, U.S. General Accounting Office, Washington, D.C.

DEAR MR. STAATS: Under the direction of Mr. Dick Halter, your office has been conducting an audit of boarding homes in the Baltimore, Maryland and Newark, New Jersey areas. GAO's audit findings were previewed at our April 25, 1979

hearings at which Mr. Gregory J. Ahart, Director, Human Resources Division, testified.

As you know, the GAO audit was limited to examining SSI eligibility and the quality of care offered in such facilities. The financial records of several of the homes GAO reviewed, i.e., Just House in Baltimore, will soon be made available to us under subpoena.

The purpose of this letter is to ask that GAO widen its field of inquiry to include a financial (fraud) audit of these homes. Our Committee staff, together with the Maryland Attorney General and the Baltimore States Attorney, would have great interest in the audit results for about a dozen homes. To my knowledge, no such audits have ever been conducted with respect to boarding homes anywhere in the United States.

Our staff is very interested in a series of related issues which surfaced during your examination, including:

Allegations that the signature of SSI beneficiaries was forged on checks by boarding home owners;

Allegations that SSI recipients were not given a personal spending allowance;

Allegations that food stamps belonging to welfare clients were converted to personal use or sold in the black market by boarding home owners;

Allegations of Medicaid fraud—that is, physicians serving boarding homes allegedly bill for services not rendered using Medicaid cards of residents which are often retained in the office of the home operator;

Allegations of drug abuse such as overmedications and of the diversion of drugs paid for by Medicaid into street traffic.

In short, testimony by your staff as well as extensive field investigations by ours, suggests that boarding homes are a focal point for a variety of federal programs including SSI, Medicaid, and Food Stamp Assistance. Since there is, apparently no single agency responsible for overseeing federal interests in this matter, and since serious allegations of misuse and misappropriation of federal resources have surfaced, a detailed cross program—investigative audit is germane to our legislative purpose.

We would appreciate your allowing GAO personnel to undertake this deeper probe of Maryland boarding homes. May I hear from you?

With warm regards, and believe me,

Always sincerely,

CLAUDE PEPPER, *Chairman.*

Mr. PEPPER. Many deplorable facts have been uncovered in the investigation. The GAO has advised that completion of our request would require access to certain books and records which can be made available only by the use of subpenas.

I am asking the issuance of subpenas en bloc to the principals of nine boarding homes as spelled out in your briefing material. Is there discussion of the matter? If not, all in favor of the issuance of the subpena, let it be known by saying "Aye." All opposed "No."

[The following members of the subcommittee voiced their vote on the aforementioned motion: Representatives Pepper, Abdnor, Bonker, Drinan, Ford, Ratchford, Stack, Hollenbeck, and Marks.]

The Chair notes that nine members having voted in favor of the issuance of the subpenas, it is ordered that the subcommittee approve the issuance of those subpenas.

Now we will hear from our first witness, Mr. Francis Mullen, at this time.

We are delighted to have you here.

STATEMENT OF FRANCIS M. MULLEN, JR., ASSISTANT DIRECTOR, CRIMINAL INVESTIGATIVE DIVISION, FEDERAL BUREAU OF INVESTIGATION, ACCOMPANIED BY JOSEPH HENEHAN, CHIEF, WHITE COLLAR CRIME DIVISION

Mr. MULLEN. Mr. Chairman and distinguished members of the committee, Judge Webster has asked me to convey his regrets in not being able to testify here today. As I left him this morning at

9:35 he was in conference. We have a hijacking underway in Miami. Apparently an individual grabbed what he thought was the pilot but who is actually an airplane washer. I don't think they will get off the ground because there is no pilot. But Director Webster is involved.

He has requested that I appear before you in his absence to discuss the results of our investigations into fraud among clinical laboratories providing services to physicians on behalf of medicaid and medicare recipients.

You have stated that the members of the committee have an intense interest in what might be done to stop fraud in Government health care programs. I would like to state at the outset that the FBI, as an organization, shares this interest and appreciates this opportunity to convey to the committee and the public the results of our investigations.

As you are aware, during 1976 and 1977, there was considerable publicity surrounding frauds in the Government funded health care industry. A number of our offices began conducting preliminary investigations into this area. Our Los Angeles Office determined through this preliminary investigation that there was apparent, extensive fraud, and kickbacks in that geographic area.

After considerable study of the various investigative approaches available, it was decided that an undercover approach would have a high probability of success and would be the most effective way to not only determine the depth of the problem, but, with minimal use of manpower, would enable the investigator to obtain direct evidence of the crimes being committed.

The statutes available for use were title 18, United States Code, section 286—Conspiracy To Submit a False Claim; section 287—Submission of a False Claim; section 1001—Submission of a False Statement; section 371—Conspiracy; and title 42, United States Code, sections 1395nn and 1396h, which prohibits the solicitation, the receipt, the offering, or the payment of any remuneration for referral or the procurement of goods or services under the medicare/medicaid programs. From analysis of the programs, the available statutes, and information from knowledgeable sources in the industry, it was determined that title 42, United States Code, sections 1395 and 1396h, would be the most viable for the purposes of investigation.

A decision was then made to begin the undercover operation with our agents representing themselves to be representatives of a large company who were interested in entering the health care industry, specifically nursing homes. These undercover agents then began contacting the providers of various services. It became apparent immediately that kickbacks and rebates were a way of life. Virtually every provider of ancillary services that we contacted made offers of rebates and kickbacks in an effort to provide the business services which would be needed to maintain a nursing home. These offers were made by clinical laboratories, therapists, X-ray services, providers of oxygen, et cetera. However, by far the most offers were made by clinical laboratories—nine direct offers.

In the first 3 months of operation, 22 cases were opened and set aside for future investigation. In addition to the offers of kickbacks, information was developed that indicated that kickbacks were

being paid to specific hospitals, nursing homes, clinics, and doctors. In summary, the initial undercover activity had obtained information which would lead to the belief that no phase of the medicare/medicaid industry is free from fraud.

During November of 1978 and January of 1979, several individuals were arrested as a direct result of the undercover operation. The ensuing publicity in the Los Angeles area led certain individuals to contact our Los Angeles office. Among these individuals was the owner of a clinical laboratory. He indicated that he was very pleased with our efforts and offered his services to assist the investigation in any way possible.

With his cooperation, undercover agents were placed into his business as salesmen. The undercover agents and the laboratory owner, working in concert, were able to identify a large number of doctors, hospitals, and clinics who would directly solicit kickbacks as a precondition to any business being given to the laboratory.

While this phase of the operation was underway, an owner of a clinic agreed to assist in the investigation both by making contacts with suspect providers and by permitting undercover agents to portray themselves as representatives of his clinic for the same type contacts.

The operation was expanded at various times throughout its duration as legitimate individuals involved in the industry would come forth and voluntarily cooperate in the investigation. One individual indicated he was losing $800,000 to $1 million per year in business due to his reluctance to participate in the kickback activity.

The operation was closed in March 1980 due to public awareness of the operation and due to the backlog of cases that had been generated which could not be investigated overtly without exposing the existence of our undercover activities.

We learned many things from the investigation, the most evident of which is that corruption has permeated virtually every area of medicare/medicaid health care industry. Also, of equal importance, we have learned that there are many honest, reliable businessmen and professional people who will do whatever is necessary to assist in removing the corruption from the industry.

Based on our experience, the methods to commit fraud in the medicare/medicaid programs are virtually unlimited. The most widely used method of paying kickbacks in this program is by cash. Generally, the payment is based on a percentage of the medicare/medicaid business generated by a particular client. A percentage paid by a particular provider to a client is usually based on the dollar volume that the client can produce in the programs.

For instance, a laboratory may receive $10,000 per month in medicare/medicaid work referred to the laboratory. Generally, the percentage agreed upon is 10 to 20 percent, but has been as high as 33 percent. This arrangement naturally provides an incentive for the doctor or client to order medicare/medicaid business that is not necessary. We have found specific instances where this is the case. A second type of kickback is free services on nonmedicare/medicaid clients. For example, if a particular client's business is 80 percent medicare/medicaid, and 20 percent private patients, a provider might agree to perform services on that client's nonmedi-

care/medicaid business for free in return for the client referring medicare/medicaid business to the provider. You can see the doctor in this case would charge the private patient, but there would be no cost to him for the laboratory work. Again, the client overutilizes the program.

Another type of kickback is the providing of supplies by a provider to a client in return for the client referring the medicare/medicaid business to the provider. Some types of supplies have been free pharmaceutical items and free business equipment.

In some instances, a kickback is paid to a client by a provider of medicare/medicaid services in the form of lease agreements. The lease agreement usually is for space rented by the client. For example, if a doctor rents space in a particular building for his office, a laboratory might agree to pay the lease on the space if the doctor will refer medicare/medicaid business at a particular volume to the laboratory.

In some instances, a provider will provide free trips to clients in return for referring medicare/medicaid business to the provider. Again, this is usually based on a volume situation and it causes overutilization of the program.

Another form of rebate encountered is the payment of the salaries of employees of a particular client by a provider. For example, a laboratory may agree to pay the salary of several nurses in a doctor's office if the provider is allowed to receive the medicare/medicaid business of the clients.

In the area of kickbacks, the project has detected a system utilized by some providers to pay kickbacks which is very difficult to penetrate unless there is an insider who is willing to testify regarding the situation. The laboratory and doctor combine to form a shell laboratory which is used to wash the kickbacks.

In your request for our testimony, you expressed an interest to know whether or not we utilized the same techniques which are described in the Senate Aging Committee report "Fraud and Abuse Among Clinical Laboratories." We did, in fact, use the same techniques initially. However, as our operation continued and with experience, it was expanded to not only receive offers of kickbacks, but to be in a position in which we would be solicited to pay kickbacks. To be quite frank, the seed that was planted by "60 Minutes" episode matured in this operation.

The principal difference between our investigation and the Senate staff investigation was that we limited our operation to the kickback area, whereas the Senate investigation involved record testing and other overt investigations that we were unable to conduct without a high risk of premature exposure. Another reason for limiting the investigation to the kickback area was because we believed this area was the first step toward committing the frauds and by attacking this point, which in fact was the weakest and most vulnerable area, we believed we could be much more effective in accomplishing our goals.

After reviewing the Senate Committee report, I have come to the conclusion that the discoveries made by the Senate staff about 4 years ago are still occurring and apparently becoming more widespread.

We have conducted investigations of these types of frauds in several areas of the country with the same general findings. In Detroit, Mich., our investigation to date has resulted in 39 convictions of which 19 were related to laboratories, 10 doctors, 7 were nursing home related, and 3 were pharmacy related cases. In Tampa, Fla., we have completed a number of investigations, however, we are still awaiting completion of prosecutive action. The majority of these cases involved unnecessary medical treatment.

The Los Angeles operation has resulted in the conviction of six individuals to date. Four of these individuals were the owners or operators of laboratories. Two individuals, one of whom was a State of California Department of Justice investigator, and the other an owner of a laboratory, were convicted of a violation of the Hobbs Act as a result of their activities in attempting to influence State medical fraud investigations involving various physicians in the Los Angeles area.

Currently, in Los Angeles, there are indictments pending involving 11 individuals and 3 laboratories, all involving either the paying or soliciting of kickbacks. Four of these individuals are doctors. To date, about 160 cases have been developed and an additional 30 to 50 indictments are expected before the investigation is concluded. Through spinoff, our investigators in Los Angeles say, sometimes two or more additional cases could possibly develop from each of the individual investigations.

We believe the people committing these frauds have—I hope our investigations are having some effect—absolutely no fear of being caught. For example, during December of 1978 and January 1979, considerable publicity was generated as a result of arrests which were openly identified as stemming from an undercover operation. This exposure had no effect whatsoever and the same undercover agents continued an expanded operation until it was closed during March of this year.

Since that time, the only effect of the publicity has been discussions during which the undercover agent and the subject accuse each other of fronting for the FBI and, afterwards, our undercover agent was able to continue dealing with this individual who accepted he was not an FBI agent. Furthermore, one of our offices has advised us that the people who commit these frauds are aware of their illegal activity, however, have decided to take the risk because they believe that if they are caught, the worst that will happen to them is that they will have to repay the money they obtained fraudulently.

Our experience has shown that fraud in this area is at best extremely difficult to detect. For example, at the time one individual was arrested, a search warrant was served for all records of his laboratory. This individual subsequently pled guilty and admitted committing fraud. A detailed examination of his records, however, failed to reveal how the fraud was being perpetrated and the individual refused to discuss the bookkeeping procedures he utilized.

I have focused on the areas of kickbacks as this is the primary area where we have had success. We have uncovered other areas involving fraud which are highly outlandish. In one instance, a doctor has been paid $2 million in a 2-year period as a result of

medicare/medicaid activities. The doctor was performing abortions on women who were not pregnant. He had instructed his laboratory staff that they were not to tell the patients the results of the tests that were conducted if they were not pregnant. If the patient somehow became aware of the results, he would conduct a physical examination, state that the test was wrong, and immediately perform an abortion.

This doctor billed for an abortion performed on a woman who previously had had a hysterectomy. Another abortion was allegedly performed on a woman who previously had a tubal ligation. In 48 separate instances, this doctor had billed for performing two abortions within 1 month on the same patients.

While conducting this investigation, it was determined that two doctors were racing to determine who could perform the most abortions in 1 day. They kept track of the completed abortions by putting check marks on their surgical gowns which were not changed between abortions.

In another area, we have found one instance in which $140,000 worth of supplies were sold to a hospital. The vendor then paid a kickback of $100,000 to a doctor.

We have another instance in which we were conducting a surveillance of a doctor who was involved in the home care program. The doctor, while making his rounds, was observed on many occasions to be lost and was constantly checking a map. Even though he was allegedly treating these same patients over a period of 2 years, we had difficulty believing he could possibly be lost in view of the fact he had been submitting billings for seeing most of the patients for at least 2 years.

There is example after example of false billings being prepared and submitted. One individual, while discussing that doctors would be receiving kickbacks based on the gross billing submitted to a laboratory, commented "if there is something I can give the doctor, the more he gets out if it, the more he is going to order, he is going to order like Dracula," referring to blood workups.

We have had problems in conducting traditional types of investigations in the fraud areas of medicare/medicaid. These fraud investigations are involved, time consuming and, at their conclusion, prosecution is extremely difficult due to the complexity of the crimes.

Our effort discloses that there does not appear to be any price competition among the laboratories rendering these services. The only competition our investigation disclosed was the competition among laboratories in the amounts offered as kickbacks.

This problem area is costing the American taxpayer substantial sums of money. Far worse is the fact that the money being lost through fraud, could be used to provide much needed medical help or diverted to other areas which have curtailed operations due to lack of funding.

The area of my concern is that with the amount of overutilization of laboratory testing, are all the tests or even the required tests being conducted? We have heard rumors that the tests are not being conducted, however, we have not found this to be true so far, although we have really not had an opportunity to adequately cover this type of fraud in our investigations. In fact we had our

undercover agents in the Los Angeles case fly to Washington to discuss their findings with Health and Human Resources.

We have briefed the Acting Inspector General of the Department of Health and Human Services and his staff as to our findings in this problem area. We are working closely with the Office of the Inspector General and, in fact, two of our most cooperative witnesses in Los Angeles were referred to us by an auditor from the Office of the Inspector General. We believe these problems can be more effectively attacked through a close working relationship, between the FBI and the Inspector General.

The FBI is continuing its investigative efforts into medicare and medicaid. Other FBI offices are currently considering establishing undercover operations similar to the Los Angeles investigations using the knowledge and experience we have already developed.

This concludes my formal statement and if you or the members of this committee have any questions at this time, I would be happy to answer them.

Mr. PEPPER. Mr. Bonker, any questions?

Mr. BONKER. Mr. Chairman, I am appalled at what I am hearing from our first witness. He is saying that corruption and fraud are so widespread and pervasive in our system, that there isn't one segment of the industry that is spared this corruption.

Just to restate for the record, because I think it is a very strong indictment on our system, he says that kickbacks and rebates are a way of life that virtually every provider of ancillary services that we contacted made offers of rebates and kickbacks. It involves clinical labs, X-ray services, providers of oxygen, physicians, and nursing home operators. No phase of the medicare/medicaid industry is free from fraud.

Mr. Mullen then continues by identifying the various forms of kickbacks. It is hard for me to believe there is that much corruption in our highly regarded health professions. What you are saying, Mr. Mullen, I think represents one of the strongest indictments of the system, and of any profession that I have heard of. I hope you well realize the extent of what you are saying today and can back it with widespread cases of abuses.

I was aware of the investigation which took place in Illinois a few years ago, by the Senate Select Committee on Aging. Some say that could have been just one bad apple in the barrel. But what you are saying to this committee is that your national investigation leads you to the conclusion that fraud is widespread throughout the country in every aspect of medicare and medicaid.

Mr. MULLEN. That is right, we base that on findings of agents who talked to individuals who didn't know they were talking for the recorder and we got a very good picture of what is going on.

In November when we previously discussed this matter, we had 230 cases pending. As of March 31, 1980, we had 684 cases pending in this area covering virtually every section of the country. We could have gone much further with our Los Angeles operation. We had to cease our operations because we were up to 160 cases and were having difficulty preparing them for court. We had 350 hours of tape recordings made through the use of body recorders, each of which has to be transcribed, corrected, and listened to by an agent

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to make sure they are accurate. It got to the point where we were in over our heads.

It has also placed quite a burden on the prosecutive resources of the Department.

Mr. BONKER. Why is it not possible to make an example of those whom you have caught redhanded? A little publicity should serve as a deterrent—you know when Members of Congress are found to be involved in corruption, everybody in the country knows about it. What you are saying is that corruption is so widespread and pervasive in medicare and medicaid and yet I doubt there are five constituents in my district who know what is happening. Why isn't it possible to dramatize what is happening so they couldn't get away with it or the risk is so great it wouldn't be worth the risk?

Mr. MULLEN. Hopefully these hearings will serve to dramatize the problem but as far as sentencing somebody for it, we have done our part, it will be up to the court system now. I do agree with the observation and think this would be very important.

Mr. BONKER. Do you feel we lack commitment or the mechanism to fully investigate and prosecute those who are guilty? It seems to me that Congress has attempted to deal with this problem in the past by passing new legislation, but my experience with HEW is that they are more preoccupied with beneficiary fraud and welfare fraud than they are with provider fraud.

Do you sense that lack of commitment or authority within HEW to deal with the problem effectively?

Mr. MULLEN. No, my only dealing with HEW is through the office and I sense a total commitment on their part. Only they could speak as to resources or need for resources, et cetera. But the Acting IG with whom I have dealt with on a regular basis is totally committed.

I think we should realize, too, our efforts today are based on previous exposure in media and previous attention by the Congress and we are now just getting into the problem. I am sure there will be a redoubled effort on the part of the FBI and HHS.

Mr. BONKER. This involves many segments of industry. What about the firms involved in the billing for the services? It seems to me, much of this fraud could be handled by computers, used by the intermediaries who pay the medicare bills. Is there some kind of a vast wasteland out there where we are incapable of having better auditing capabilities?

Mr. MULLEN. I don't know if it is a vast wasteland, but we should have a better auditing program. Just because the billings are computerized doesn't prevent us from investigating. In fact, we have in one case, through search warrant obtained the data base for a billing case in Oklahoma.

Mr. BONKER. Do you find complicity?

Mr. MULLEN. I can't speak of a specific case, but yes, we do find complicity.

Mr. BONKER. Thank you for your excellent testimony.

Mr. PEPPER. Thank you, Mr. Bonker.

Mr. Whittaker.

Mr. WHITTAKER. Thank you, Mr. Chairman.

I apologize to the chairman and the committee for arriving late but that testimony of yours which I have been able to absorb, is extremely revealing.

From a philosophical view, during the conduct of your investigation, do you feel like the primary problem could best be addressed by four options:

First, do you feel like it is more of an indictment of our present criminal system, our court system, that these types of flagrant abuses can be perpetrated against consuming public and allowed to continue and that the investigations which you refer to are extremely complex and even when concluded, the prosecution of the offenders is very difficult?

So, if you will, is that the approach that maybe we need to address or do you feel like there is an inadequacy in the local volunteer control within the medical societies or judging upon the conduct of all, the referring or ordering physicians and/or the performing and complying clinical laboratory?

I notice they both have societies that should be held accountable if not on a local basis, then a State and certainly a national level where abuses in their segment are addressed. They would have a vested interest to clean up their act immediately for fear of disclosure and embarrassment to the association.

Would stronger legislation maintained at the state level be of any assistance?

The last option would be that within the recommendations of this committee opportunity to recommend, but that of Federal legislation and/or stronger mandates to appropriate agencies. The Federal Registry might give you a hand.

Mr. MULLEN. I wanted to make clear at the outset, that by my testimony, I don't intend an indictment of the system. The programs are certainly well intended and I would hope a majority are handled honestly and properly. It is not my purpose to come here and say the programs are improper. My testimony is an indictment of those who misuse the system. And it is an indictment of the people in it.

Perhaps there is some inadequacy in the professions, the societies who could clean their own house, so to speak. I am certain more could be done in that area. Stronger State control or legislation would be effective and I cite in my statement the State of New York which has a very effective program of investigation and they are doing an outstanding job and have developed cases comparable to those developed on the Federal level.

The last recommendation, couldn't read my own note, what was that?

Mr. WHITTAKER. Federal legislation.

Mr. MULLEN. The competition seems to be as between the laboratories, who can give the most to get the business. If some sort of bid were set up and put the laboratories on a regional basis so the clinics and doctors would have only one place to turn to, and there would be no need to compete, if we eliminate that kind of competition to a bid on a regional basis, it might be helpful. I am sure the staff of the committee might want to study that further.

In working with HHS, we suggest to this committee and will suggest to them, perhaps a regular testing of the various laborato-

ries and doctors in the program through sending individuals in under cover to be tested and just see how the program is being used, perhaps something along those lines might be helpful. Those are the basic suggestions I have to eliminate the competition.

Mr. WHITTAKER. I appreciate your comments. For my purpose, whether to my fault or credit, I am not an attorney, but I would like to come back and pose that first question. I cannot accept your casually passing off that the criminal system or the procedural requirements to bring to prosecution those offenders is beyond improvement, be it maybe through another branch of government or committee, judiciary branch, of course, but to enable the procedures for prosecuting those offenders, making that more effective I believe would be the more direct approach. I would appreciate it if you could expand.

Mr. MULLEN. I touched on the issue earlier when I indicated the increase of the number of cases we have within the FBI. I think most members of the committee are aware we have redirected our resources at the Federal level, not only the FBI but the entire Justice Department, into the white-collar-crime area. We are just getting into this, and there will be improvement as we develop the cases and techniques. Your suggestion that we improve the administration of justice in this area is something that is occurring at this time.

For instance in Los Angeles, we found we so burdened the U.S. attorney's office with the 160 cases; the opinion was they could handle about 4 a month, with all the transcriptions that had to be prepared for court. This is something we are learning more about and we will dedicate more resources to. I am sure the U.S. attorney's office will devote more attorneys to the prosecution of these cases. So what you suggest is being done at this time.

Mr. WHITTAKER. Thank you.

Mr. PEPPER. Thank you, Mr. Whittaker.

Mr. Biaggi.

Mr. BIAGGI. Thank you, Mr. Chairman.

Thank you, Mr. Mullen.

Although I arrived late, I have read your testimony and listened to a portion of it and am thoroughly impressed with what you have presented. In my own area, New York, the same situation prevails. Deputy Attorney General Charles J. Hynes of my State a week or two ago put in an indictment of some 39 pharmacists who were selling drugs. The trade names were ordered and prescribed, and instead, generics were provided. The customer, however, was charged for the trade-name drug.

I do not know if you have already spoken on the topic of pharmacists in the different institutions. I have learned through hearsay—but I have enough confidence in the sources to believe it to be a fact—that in order to be a pharmacist in those institutions, you are required to kickback. You are right, there is competition in the amount kicked back. You also cited an astounding figure. I must pose a question to you. You stated there was $100,000 in kickbacks for a $140,000 contract. I would have to assume there would still be some profit in it for the principal involved.

Mr. MULLEN. That is correct.

Mr. BIAGGI. If that is the case, it makes one hell of a case for cost-containment, does it not?

Mr. MULLEN. Yes.

Mr. BIAGGI. I am not deceived or impressed with the fact that we are dealing with a professional element in our society. They are just as venal as any other group except they have done it under a mantle of respectability and have exploited their honored professions. There are probably many who simply take advantage of the dollars available, and that is why you have the skyrocketing costs in some measure.

One question—what will be the exposure, liability for those found guilty?

Mr. MULLEN. I have Mr. Henehan, chief of the white-collar-crimes division. Joe, do you know the penalties?

Mr. HENEHAN. I can give you anticipated penalties. It has been a practice in these matters that individuals are fined and placed on probation. There are very few instances where prison terms are given. However, I have to qualify that statement by saying in the recent past, I have seen a change taking place where we do have professional people being given prison terms. I think it is a tragedy when a professional has to go to jail, but I cannot help but comment that I think it is going to have impact, when we see some of these criminals being sentenced to jail.

Mr. MULLEN. I am told title 42 penalty is 5 years.

Mr. BIAGGI. We did that 3 years ago, apparently.

I understand the general rule of fines and probation and frankly, I am not bloodthirsty, but certainly all of the professionals, all the components of this health delivery area, should be made aware in very certain terms that this is what they face.

I also believe that it should be spelled out to them, the game they played and the punishment they will receive. From here on in, it is "hardball." They should at least be given notice, otherwise, you will find yourself deluged. Many may have been victimized by practical modes of living, for example, competition in business, but I would say from here on in, they should be made aware and alerted to the consequences.

It is interesting, Commissioner Hynes in New York is doing a tremendous job and has done a great job in these areas. What they are trying to do now is eliminate his office by cutting down his investigative office and putting him in the attorney general's office. That is one way of subordinating his importance. Once that has been accomplished, your ability to fund will be diminished. I would not be surprised if professional societies, whether institutional or otherwise, might be expressing those thoughts to receptive ears.

Your activity in Los Angeles is another example of the monumental nature of the problem and your inability to deal with it. I understand we have someone from HEW here, but how is the cooperation with HEW?

Mr. MULLEN. The cooperation between the FBI and the Inspector General has been outstanding. Many of the cases we have developed have been based on referrals from HEW. So, there is an exchange of information. As I indicated earlier, we had our agents come in and brief the HEW staff on what we found to give them

thoughts and ideas as to what to look for. So I have no complaint at all regarding the cooperation between the two agencies.

Mr. BIAGGI. What about the resources of the IG? Is he limited?

Mr. MULLEN. I cannot answer that, Congressman Biaggi. He is present and will answer it.

On a national level, the cooperation and exchange of information is outstanding. So I really cannot comment further. When we have problem areas, as you often do, on a local level, we are able to go to the national level and get them resolved. It is working.

Mr. BIAGGI. I appreciate the work the FBI is doing. You are doing an excellent job in revealing the depth of the problem. You said something about dramatizing and letting the people know; that, I think, will be the most important component of the whole undertaking at this point, letting all the people know, let the professionals know, the potential culprits as well as the potential victim.

This is a very important hearing. The substance touches all of us in many, many ways. It affects clearly national health insurance, which is the desire of all people in our country, cost being the critical factor, and yet I do not know what members of the press are here, not for our personal aggrandizement, but expanding on the issue. It is that kind of exposure the issue requires. It is a national scandal, frankly, it has a potential of being even worse. Further investigation will reveal its true depth, and yet we are having this hearing in almost total privacy. That is the shameful part of it. That will be the challenge for all the people, all the agencies involved, as well as the Congress. Hopefully, we can synthesize in the issue.

Mr. MULLEN. I concur in everything you say.

Mr. PEPPER. Thank you Mr. Biaggi. Mr. Ratchford.

Mr. RATCHFORD. In connection with this report, how many investigators did you provide?

Mr. HENEHAN. We cannot give you an exact number. The report covers not only Los Angeles.

Mr. MULLEN. The number of cases, 684 cases covers the entire country.

Mr. RATCHFORD. Can you then indicate how many States are involved in which you have held these investigations or roughly a percentage of the 50 States in which you investigated?

Mr. HENEHAN. We have 59 field offices, I would say every State must have some cases.

Mr. RATCHFORD. You are suggesting that the report applies to the 50 States?

Mr. MULLEN. Yes. Some offices are more advanced than others in their investigations. It is something we could prepare for you. I would not think there would be a real problem.

Mr. HENEHAN. We can give you a breakdown.

Mr. RATCHFORD. That would be of assistance.

You make the statement on page 3. Are you suggesting every provider is doing this, getting kickbacks?

Mr. MULLEN. No, those we had developed intelligence about and had beforehand information that there would be offers of kickbacks.

Mr. RATCHFORD. Based upon your experience, or of your unit, do you have an estimate of the percentage of the professionals involved?

Mr. MULLEN. No, I do not. It is a difficult question to answer, like how much white-collar crime there is and what percentage of the industry. I could not say 20 percent, 30 percent, because I could not support it if I did.

Mr. RATCHFORD. What do you then mean by the statement that no phase of medicare was free of fraud?

Mr. MULLEN. In those cases where we had investigations, based on FBI experience.

Mr. RATCHFORD. Have you statistics as to the percentage of convictions as a result of your investigation cases and prosecutions?

Mr. MULLEN. Yes.

Mr. RATCHFORD. Can you indicate that for the committee?

Mr. MULLEN. I will obtain that for you and make sure the committee has that information.

[See appendix, p. 37 for material subsequently received from Mr. Mullen.]

Mr. RATCHFORD. Can you characterize it as a high percentage?

Mr. MULLEN. A high percentage of conviction and many guilty pleas.

Mr. RATCHFORD. You indicate in the report that it is difficult to obtain convictions. Are there shortcomings in the law and if so, would you care to comment on them?

Mr. HENEHAN. Yes. There is difficulty in proving the cases in many instances.

By way of example, we have a summary of problems we encountered down in Florida. Included there were such things as doctors' visits. A doctor is paid to visit a patient. We have found instances where the doctor reviewed the patient's chart and charged for a visit to the patient.

This is a gray area. This is accepted in certain instances. We thought we had a criminal violation in those instances; we were in a gray area. That would be an example of the type situations we identify, where it is very difficult to say a crime is being committed for false billing.

Mr. RATCHFORD. This committee, I am sure, would be interested in the law. We are a select committee so we cannot report legislation directly to the floor of the House, but the record of Senator to the floor of the House legislation, but the record of Senator Pepper has been outstanding in being able to persuade Members of Congress that legislation is necessary, and I am sure he would pursue this with great vigor if you would provide this information.

Mr. MULLEN. We would have to work through the Department of Justice. I would like to make available for the committee our report of the Tampa investigation, it is dated February 6, 1978, which includes recommendations of the agents. You might find it helpful.

Mr. RATCHFORD. We do appreciate receiving a copy of that.

[Material retained in committee files.]

Mr. RATCHFORD. I assure you based on my 2 years' experience in chairing a committee on nursing home violations, this committee is interested in seeing that Federal dollars are not wasted, and to see

where quality of life is improved. We would be most pleased to receive your recommendations in that area.

As Congressman Bonker said, this is appalling. If every State has examples of this, it is truly appalling.

I yield back my time.

Mr. PEPPER. Thank you, Mr. Ratchford.

Mr. Stack.

Mr. STACK. Mr. Chairman, I have heard this testimony and listened with great interest and rather mixed feelings. My initial feeling has to be of complete outrage as to the extent of the fraud perpetrated on a segment of our society which can least afford to be victimized.

Also, I reacted with a feeling of discouragement, having spent a good deal of my life in the field of human services and in law enforcement. I know what the FBI is up against in getting convictions in the white-collar field. You can get convictions, but fines are not adequate to deal with the situation.

I think we need to translate our outrage into legislation, as Mr. Ratchford is suggesting and as others have suggested. One of the problems I see is that if we do not act promptly upon the conclusion of these hearings, we will simply provide ammunition to those who would like to cut the budgets for human services.

Indeed we must present to the American public that the funds for medicare and medicaid activities, are being well spent and are not being flagrantly wasted in the practices which you have so adequately described this morning.

I think you have done a magnificent job here. I realize you have a tremendous job in prosecuting these cases. You cannot inundate the investigators, you defeat your purpose, but I do hope we will see long prison sentences and the system as a whole will not simply give these people a slap on the wrist. If we do that, we will encourage more of the same. But more importantly, I think we must insure that we restore the confidence of the American public in what Congress is doing in this field, by appropriate legislation, which we will then vigorously enforce.

I thank you very much for your testimony.

Mr. PEPPER. Thank you, Mr. Stack.

Mr. Mullen, just two or three questions by way of summary. In how many areas in the country has the FBI conducted this investigation?

Mr. MULLEN. We have conducted investigations in all areas of the country. As Mr. Henehan indicated, we have 59 offices throughout the country. Each has some cases but the large offices such as Los Angeles and Detroit have much larger programs.

Mr. PEPPER. You have cases in Tampa, also.

Mr. MULLEN. Yes. We have cases going in Tampa.

Mr. PEPPER. Now, in what areas of the health care industry did you find these conditions to exist?

Mr. MULLEN. In virtually all areas, but real problems with regard to the laboratories and with regard to the nursing homes.

Mr. PEPPER. Nursing homes and laboratories.

What about the doctors, were they involved in it?

Mr. MULLEN. In some cases, yes, there would have been doctors involved.

Mr. PEPPER. What kinds of wrongdoing were most generally discovered?

Mr. MULLEN. Kickbacks.

Mr. PEPPER. Fraudulent claims?

Mr. MULLEN. Kickbacks were most prevalent, followed by fraudulent claims, work billed for but not performed.

Mr. PEPPER. How many indictments?

Mr. MULLEN. Yes; we have had many indictments. Based on a question by Mr. Ratchford we will be providing you with a list.

Mr. PEPPER. How many convictions, if any, have you had so far?

Mr. MULLEN. I do not have the figure, but I will provide it to the committee in written form.

Mr. PEPPER. In the case, you say a doctor submitted a bill for having visited a patient. If the English language means anything, if I were to say to you that I visited you, you cannot misunderstand that. I did or did not. It might be equivocal if I said I talked to you which raises questions of whether it was on the telephone instead of going personally. They might quibble about that, but the word "visit" means you have some proximity of contact with somebody. I visited so-and-so.

That chart is prepared ordinarily by the nurse or by the physician. You are suggesting that even if you looked at the individual personally, the chart may not always be correct.

Mr. MULLEN. That is right.

Mr. PEPPER. So, it seems to me the doctor owes it to the patient to exercise individual judgment as to how best to bring about his improvement.

Mr. MULLEN. That is where a tightening of the regulations might be helpful, where a visit by the physician would be personally contacting the patient.

In the Tampa investigation, there was some question as to whether reviewing a chart constituted visiting a patient. Mr. Henehan cited that as some of the difficulty we run into.

Mr. PEPPER. Can't the agency enforce the regulation?

Mr. MULLEN. That is generally the problem we had in Tampa.

Mr. PEPPER. What is the general problem in Tampa?

Mr. MULLEN. Providing unnecessary treatment. Many of the patients would go for treatment and end up having unnecessary treatment performed.

Mr. PEPPER. In those cases, did the medical authorities withdraw?

Mr. MULLEN. I do not know the status, and the cases have not come to trial yet, so I would tend to believe that no action could be taken until there was some court action, so I would answer no. I do not think anything was withdrawn.

Mr. PEPPER. Other than stealing money from a sick or invalid person, it is just about as low a crime as I can think for somebody who is a provider of health care for the elderly people of the country but is actually denying health care to people by making false claims and making the program cost more than it should. There is only a certain amount of money, and the more you waste it, the less there is to purchase needed health care. So, those who do perpetrate those frauds ought to be stigmatized not only by punishment by the courts, but also by the community, and they

ought to be deprived thereafter of the privilege of participating in the program, it would seem to me. If you will excuse us, we have to go vote.

Mr. BONKER. We have about 10 minutes.

I can raise a question. You stated you—on second thought, I think we should follow the chairman's recommendation to recess for a vote, then we will come back.

Mr. PEPPER. Mr. Grassley, the ranking minority member of this committee, was unable to be here today. He regrets very much that he cannot be here. He has sent a statement which he wishes to incorporate into the record, which without objection, will be received.

[The prepared statement of Representative Charles E. Grassley follows:]

PREPARED STATEMENT OF REPRESENTATIVE CHARLES E. GRASSLEY

Mr. Chairman: In June 1976, the Senate Special Committee on Aging held a hearing on Fraud and Abuse Among Clinical Laboratories. This hearing, based on an extensive pre-investigation, provided evidence of illicit laboratory practices and kickback schemes between doctors and clinical laboratories that defraud the government of hundreds of millions of Medicare and Medicaid dollars.

In April of 1978, the H.E.W. Inspector General issued a report which estimated losses in the billions of dollars in H.E.W. programs resulting from fraud and abuse. Of this, the estimated loss of Medicare alone exceeded $2.2 billion in fiscal year 1977.

In October 1978, following extensive pre-investigation, the House Select Committee on Aging held a hearing on Fraud and Racketeering in Medicare and Medicaid. At the hearing, the testimony of numerous highly knowledgeable witnesses, to include The Honorable Griffin B. Bell, Attorney General of the United States, attested the widespread encroachment and expansion of syndicated crime in Medicare and Medicaid program administration.

Today's hearing, again based on the incontrovertible evidence of investigative work, is a follow-up to the 1976 Senate hearing. This time, witnesses include representatives from the Federal Bureau of Investigation and the H.E.W. Inspector General's Office. I presume that these witnesses will outline the steps that are being taken to identify transgressors and to root out this crime. I know that I am joined by my colleagues in the hope that their testimony will assure us and the taxpayers of America that the effort is of the magnitude and the vigor needed to restore honesty and ethical practice where it is lacking in this area of medical service to the poor and the elderly.

In closing, I want to express a personal sense of outrage over this situation. Doctors and laboratory clinicians are trusted professionals. Those who break that trust for greed must be sought out and prosecuted. To deliberately neglect honest laboratory techniques is to express a criminal contempt for human life. Since the post-retirement years are generally marked by an increased fragility of health and a critical dependence on proper diagnostic services, it is doubly reprehensible to subject the elderly to these nefarious practices.

From 1976 to 1980 is a long time. The Executive Branch is moving too slowly and too indecisively in its attack on fraud and abuse in this area.

Mr. Chairman, I commend the purpose of this hearing and I recommend the unrelenting oversight action of this Committee until corrective action is raised to our level of satisfaction.

Mr. PEPPER. Mr. Mullen, have you any additional suggestions other than what you have said in trying to deal with and deter these nefarious persons?

Mr. MULLEN. No, Mr. Chairman, I think a report of our investigation might be helpful.

Mr. PEPPER. Our committee would like to follow up on your statement and do everything we can to try to weed out the fraud which is in these two programs. It means too much to too,

many people. The ripoff artists are doing a great disservice to a great many people in the country. We would like to keep in touch with you and find out how many are indicted, how many are convicted, and see if we cannot get due publicity. Some of those folks ought to go to the penitentiary, and the community should know they have been to prison. Some may say give them a little probation, which the judges often do, a little remonstration or a fine, much less than the amount they have been able to rip off, but I think there need to be serious penalties for persons committing those crimes.

Mr. MULLEN. You may contact our office and we will check with the Department of Justice to see that they approve.

Investigations must not be looked upon as being antiprogram. That is not the case. In fact, I think a thorough reinvestigation in many cases enhances the program and more people benefit from the intent.

Mr. PEPPER. As you say, this is to preserve the integrity of the program.

Thank you very much, Mr. Mullen. We appreciate what the FBI has done in this matter.

We will appreciate it if you convey our thanks to Judge Webster and the FBI.

Mr. MULLEN. I will do that.

Mr. PEPPER. The next witness Mr. Richard B. Lowe, Acting Inspector General, HEW.

We are delighted to have Mr. Lowe here today.

Mr. Lowe, you may summarize your testimony, if you care to submit it for the record, we will put it in the record in full, then that will give us the opportunity to ask you questions about the testimony.

Mr. LOWE. Thank you, Mr. Chairman.

Mr. PEPPER. Without objection, your full statement will appear in the record.

STATEMENT OF RICHARD B. LOWE III, ACTING INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JAMES KERR, ASSISTANT REGIONAL AUDIT DIRECTOR, SAN FRANCISCO; AND NICHOLAS BOURNIAS, SUPERVISING AUDITOR, HEADQUARTERS

Mr. LOWE. I have asked to accompany me, Mr. James Kerr, Assistant Regional Audit Director in San Francisco; and Mr. Nicholas Bournias, Supervising Auditor here in headquarters.

Mr. PEPPER. We are delighted to have you here. You may assist Mr. Lowe or make any statement you may wish.

Mr. LOWE. I should point out to you, Mr. Chairman, that Mr. Kerr worked with the members of the FBI in the investigation which occurred out in Los Angeles. He is the person who they referred to in their testimony in terms of supplying key witnesses to the FBI in cooperation with their investigation.

I should also say we were briefed with respect to that investigation. As a matter of fact, we have discussed the possibilities of a joint investigation with the FBI, a commitment of our audit resources along with their expertise in criminal investigations and a joint pooling of financial resources. I should point out, as a matter

of fact, in the 1981 budget which I have submitted, I have asked for a million dollars in appropriations for special fraud and abuse initiative. It would be these kinds of joint projects which I would hope to use these funds for.

Mr. PEPPER. In the area of medicare.

Mr. LOWE. Medicare, medicaid, and fraud in the other programs which we have the responsibility to administer.

I want to thank the committee and you, Mr. Chairman, for the opportunity to appear before you today. Your efforts and the support of other congressional committees have been a major impetus behind the creation of the Office of the Inspector General and have enhanced our ability to combat the kinds of problems we are discussing here today. The previous congressional report on fraud and abuse among clinical laboratories dramatically documented the need for a more critical look at clinical laboratories.

I have been the Deputy Inspector General for the Department since August 1979, and I have been the Acting Inspector General since October 1979.

My statement documents the efforts our Department is attempting to make and is making at this very time, to control and combat the corrosive effect of those who would take advantage of the programs which the Department of Health and Human Services has the responsibility of administering.

I would just like to say this: there are two aspects, as I see it, in terms of the Inspector General's responsibilities. One is to effectively combat fraud and abuse with respect to the programs which Health and Human Services, formerly Health, Education, and Welfare, has the responsibility of administering. But we also have the responsibility in the Inspector General's Office, as you know, to assist in the fostering of economy and efficiency in the operation of those programs.

Quite frankly, the efforts of our office are strongly geared toward systemic improvements. We take a hard look at the administration of the programs, so that by hardening up the soft spots, if I might say, we can then eliminate the opportunities of those who would attempt to take advantage.

Toward this end, we have a history of developing a systematic way of looking at programs such as the medicaid program and, more particularly, the clinical laboratories in terms of developing methods by which the States can oversee and effectively monitor the medicaid program.

We launched, in I believe it was 1977, an effort which has been known as Project Integrity I, which was designed to look at the billing practices of physicians and pharmacists. their practices in billing the Government for medicaid and medicare services.

We developed computer screens to surface what I like to call "targets." In other words, one of the problems with examining the process is where do you begin? Who do you look at? The audit agency is responsible for developing a system by which computer screens surface aberrant billing practices and thereby give our Office of Investigations a pool of people to examine.

The second effort, which is described clearly in my statement, grew out of Project Integrity I, and that was Project Integrity II, which was designed to look at clinical laboratories. It began with a

pilot project in California. We worked very closely with the State of California and selected some eight other States. Our attempt there was to look at the billing practices of the clinical labs, their methods of billing, the types of billings they would submit to the Government, so that again, the States could have a grip and a handle on how to examine, how to look at, how to investigate and oversee those laboratories.

I would like to submit for the record, Mr. Chairman, two documents. One is a lessons-learned document of Project Integrity I, which documents the efforts, the process, and the development of the computer screens and how these programs in effect can be looked at systematically.

The second document is what we call a "how to book," describing project initiatives to help identify fraud and abuse in health-care projects. This has been disseminated to every State in the Union, to give them an ability to develop techniques.

[Material retained in committee files.]

One of the points that was well made by Mr. Mullen was the fact this is a burgeoning area. Fraud and abuse in the health care industry is a very recent—let us not say that the instance of fraud and abuse is a recent phenomenon——

Mr. BIAGGI. Revelation, is it?

Mr. LOWE. No; the techniques to detect it, the techniques to develop ways to ferret it out are recent. Indeed, the entire criminal justice system has only recently, I would say within the past 7 to 10 years, turned its attention from, not totally from, but from the street criminal, the violent criminal, to what we call the white-collar criminal. Indeed, the distinction between the two is evident. We have dressed him up, giving him a modicum of respect. The treatment of this criminal is different than the treatment of the street criminal.

Joe Hynes has been a pioneer in this area and that is one of our very positive efforts.

Mr. PEPPER. Has your work resulted in many convictions, and are any people going to prison for medicare-medicaid fraud?

Mr. LOWE. We have been receiving an increase in the number of our convictions with each year. In addition, I should point out that one thing we are very positive about, Mr. Chairman, was the passage of the legislation creating the section 7 fraud control units. These are State units funded by my office. My office oversees these State fraud-control units, we certify and recertify them, we fund them up to 90 percent of their operations, and Mr. Hynes is the Director of one of them. There are 28 such fraud control units in existence now, and we are encouraging those States which do not have them to get them. We view them as extensions of the Inspector General's Office across the country. Every department is limited in their resources. But the pooling of the State resources, the cooperation between our office and the FBI will show some dramatic results in the not too distant future.

I would be very happy to answer questions, sir.

[The prepared statement of Mr. Lowe follows:]

PREPARED STATEMENT OF RICHARD B. LOWE III, ACTING INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman, members of the subcommittee: I want to thank you for the opportunity to appear before you today. Your efforts and the support of other congressional committees have been a major impetus behind the creation of the Office of the Inspector General and have enhanced our ability to combat the kinds of problems we are discussing here today. The previous congressional report on fraud and abuse among clinical laboratories dramatically documented the need for a more critical look at clinical laboratories.

I have been the Deputy Inspector General for the Department since August 1979, and I have been the Acting Inspector General since October 1979. As you know, our Office of Inspector General was authorized in 1976 by Public Law 94-505, and this action created in HEW the first statutory Office of Inspector General. One of my mandates is to provide leadership and coordination, and recommend polices designed to promote economy and efficiency. I have worked to mold three different disciplines—auditors, investigators, and systems analysts—all highly skilled and specialized, into a cohesive management unit to combat fraud, program misuse, and management inefficiency. Our efforts are thus more effective because we operate in multi-disciplined teams.

This gives us the very valuable capability not only to detect and investigate current problems, but also to evaluate deficiencies which permit mismanagement, fraud or abuse and to recommend corrective action.

My predecessor, Mr. Tom Morris, placed great value as I do on the clinical lab congressional report. To some extent this report was the catalyst for our Project Integrity I, in which we utilized computer screens developed by our auditors with assistance from medical and pharmaceutical consultants, to identify physicians and pharmacists nationwide whose billing practices in the medicaid program appeared to be aberrant. These preliminary findings were examined more closely and eventually led to the filing of over 1,000 criminal cases. To date there have been 69 indictments involving 65 individuals and 4 firms. Thirty-two cases have ended in convictions (41 individuals and 2 firms). Over $6.3 million in medicaid/medicare overpayments have been identified and at least $7 million in annual savings will be realized from system improvements. Cases involving malfeasence or mismanagement have resulted in administrative sanctions.

We found Project Integity I to be a valuable learning experience. We disseminated Lessons Learned, a booklet describing our effcrts and experiences to all 51 participating jurisdictions for their use in developing similar projects. More specifically, however, we confirmed what we suspected about clinical labs—that fraudulent practices were ongoing and widespread.

In November 1977, in conjunction with the California Department of Health Services, we initiated a pilot project for the review of laboratory practices in the State of California. This pilot project led to similar initiatives in other States that we refer to as Project Integrity II.

Nine computer programs were developed to identify the most apparent cases of excessible billing practices. Most of the parameters used in these programs were developed in consultation with clinical pathologists and other physicians. We also met with representatives of medical and laboratory associations to review with them our proposed computer programs and project methodology. Pilot audits of providers were conducted and the results of these reviews were used to modify our computer programs. From the computer printouts those laboratories and physicians whose patterns indicated a high potential for fraud and abuse were selected for more extensive analysis.

Some of the abusive and fraudulent practices disclosed by the Federal/State teams included:

Billings to Government programs at greater rates than those charged to physicians for the same lab tests. In one case, a laboratory billed medicaid $176 for a profile of tests. Its published fee to physicians for the same profile was only $33. We reviewed price lists at 30 different laboratories, and for 35 frequently ordered tests, we determined that the maximum amounts allowed by the State were generally much greater than the prices quoted to physicians.

Billings for lab tests that were not done. One lab, for example, billed for urinalysis tests even though the ordering physician failed to provide the required urine specimens. In another case, a lab claimed to have performed sensitivity tests, although the initial culture tests on the specimens were negative and sensitivities could not have been made.

Billings for individual chemistry tests that were in fact done as part of automated panels.

Billings for more expensive tests than those ordered by physicians. At one lab, physicians ordered a test costing $4 but the lab conducted a different test for which it received about $22. In another situation, a lab performed additional tests which had not been ordered by the physicians and were not apparently needed by the patients.

Improper profiteering on lab work performed by subcontractors. A lab had a test done by another lab at a cost of $12 and billed the medicaid program $22 for the tests.

Physicians claiming to have performed lab tests in their offices when, in fact, the work was done in outside independent labs. In these cases, the physicians billed the medicaid program more than their costs and thereby received payments to which they were not entitled. As an example, one physician had a panel of six tests performed in an outside lab at a cost of $7 but billed medicaid for six individual tests for a total of $42.

The individual examples which I have cited are minor in amounts. However, with the use of special computer techniques and statistical sampling methods, we have been quantifying the overall extent of improper payments, some of which have been quite substantial.

Since the inception of the pilot project, we have identified in California about $3,350,000 in overpayments and referred 20 cases to investigative organizations. Our efforts in this project have been supported by the Health Care Financing Administration (HCFA). We also cooperated with the FBI and provided them with information on potential problem laboratories and physicians as was described in the Bureau's testimony.

The problem of price discrimination and high payment levels for tests was brought to the attention of the California Department of Health Services, which issued proposed regulations to: (1) Tighten the requirements prohibiting labs from charging Medi-Cal more than physicians; (2) lower the maximum allowances for some of the tests; and (3) prohibit labs from billing individually for tests that are performed on automated lab equipment. The State estimates that these proposed changes, if issued in final form, would produce annual savings of $4 million.

We have also made a number of recommendations to the State to help strengthen controls over the payment of lab tests. One of the most important recommendations concerns the awarding of competitive contracts for lab services. The State has been considering awarding competitive contracts, and we support this concept on a demonstration basis. This proposal has several merits.

In terms of potential fraud and abuse, competitive contracts would enable the Government to tighten up the payment process. The Government would be able to more effectively monitor and audit the contractors' labs. Competitive contracting for lab services also has the potential for producing significant program savings.

During the past year, the joint Federal/State laboratory project was expanded to seven other States and designated as Project Integrity II. The participating States are: California, Texas, New York, Washington, Michigan, Hawaii and Massachusetts. Some accomplishments to date are:

New York referred 18 cases for full-scale fraud investigation, estimated program savings on just three of these cases total $1,220,000.

Michigan expects to recover $111,500 in overpayments, and projects savings of $236,000 per year.

Washington identified approximately $150,000 in overpayments.

In Massachusetts, $12,400 in duplicate claims were identified.

During fiscal year 1980, we plan to initiate audits of laboratory services in six more States. The audits will primarily concentrate on: (1) The problem areas noted during our review in California; (2) the billing practices of selected physicians and laboratories; and (3) the adequacy of State agency procedures for monitoring the propriety of such billings.

As a result of our work in Projects I and II, we and the Department have taken steps to alleviate the problems encountered in clinical laboratories. One of the most significant steps, we feel, has been our support for the establishment of State fraud control units to detect and prosecute provider fraud in the medicaid program, including fraud perpetrated by clinical laboratories. As of today, the fraud control units have either investigated or are in the process of investigating some 120 cases involving clinical laboratories.

While the principal reason for the creation of these units it to assist case-by-case investigations and prosecution of individuals and firms that defraud the medicaid program, some of the most beneficial effects of their investigations result from the identification of State agency actions, or omissions—which have permitted fraud. We have produced a report which contains, on a State-by-State basis, descriptions of program, regulatory, and statutory deficiencies which the units have uncovered

thus far, as well as recommendations for corrective action. We believe that the activities of these units in the long run will not only deter providers, including clinical laboratories, from fraudulent activities, but also improve patient care. As a result, we vigorously endorse current legislative proposals which would extend the period of Federal funding for the units at a level sufficient to ensure their continued and even expanded level of activity.

We have also worked closely with program officials to develop recommendations for new legislation, and here are four excellent examples.

Recommendations to amend the medicare statute to permit the Secretary to make agreements, including exclusive supplier agreements, and to negotiate payment rates with suppliers of laboratory services, durable medical equipment, and other medical equipment and supplies. This proposal has been transmitted to Congress as part of the administration's medicare/medicaid amendments of 1980, and is estimated to result in cost-savings over $100 million by 1985.

Recommendation to seek legislation to prevent independent laboratories from charging fees to the medicare and medicaid programs which exceed their charges to physicians. This requirement will be unnecessary if the proposal above becomes law.

Recommendation to amend statutory language to clarify the provisions of current law establishing penalties for bribery of officials administering the medicare program (including employees and agents of State governments and of carriers and fiscal intermediaries) and for bribery by or on behalf of providers and others furnishing items and services under title XVIII.

Recommendation to establish statute incentive arrangements for special financing to meet individual State needs for management information systems. This also resulted in legislation introduced in the current Congress.

I hope this information has been helpful to you. Again I would like to take this opportunity to thank you for letting me appear before you today. I shall be glad to answer questions or furnish the Committee additional information.

Biography of Richard B. Lowe III

WORK EXPERIENCE

October 1979–Present: Acting Inspector General, Department of Health, Education, and Welfare.

January 1979–September 1978: Deputy Inspector General (and Deputy Designate), Department of Health, Education, and Welfare. Confirmed by the U.S. Senate on June 19, 1979.

October 1976–June 1979: Assistant District Attorney and Chief of the Trials Division, New York County District Attorney's Office. Supervised 200 trial attorneys and 80 supporting staff involved in processing 120,000 cases annually.

May 1976–October 1976: Chief, Trail Bureau, New York County District Attorney's Office.

May 1975–May 1976: Chief, Early Case Assessment Bureau, New York County District Attorney's Office. Developed a unit to screen all felony arrests in Manhattan, New York.

May 1974–May 1975: Chief, Complaint Bureau, New York County District Attorney's Office.

May 1973–May 1974: Chief, Major Felony Program, Supreme Court Bureau, New York.

May 1971–May 1973: Deputy Chief, Supreme Court Bureau, New York. Served as Senior Trial Counsel.

1968–May 1971: Trial Attorney, Supreme Court Bureau, New York.

August 1967–1968: Criminal Law Investigator, New York Complaint Bureau.

OTHER

Born July 26, 1941, New York, New York.

B.S., University of Wisconsin, 1964.

J.D., St. John's University School of Law, New York, 1967.

Member, New York State Bar since 1968. Admitted to U.S. District Court, Southern District of New York, August 1973.

Lectured at Fordham, St. John's, Hofstra and Cornell University Law Schools, and also served as a faculty member for the Homicide Investigator's Course of the New York City Police Department.

Professional affiliations include: 100 Black Men; the National Association for the Advancement of Colored People; the New York State District Attorney's Association; the National District Attorney's Association; the Harlem Lawyer's Associ-

ation and the New York State Bar Association; Big Brother Organization, National Capital Area.

Mr. PEPPER. Mr. Biaggi.

Mr. BIAGGI. I would like to pursue a line of questioning relative to the resources and activities of HEW.

Frankly, it gives me pleasure to pose the question to you, because I harken back to the years I was in the New York Police Department and worked in the same area. We both survived somehow.

I would like to pose a question which in actuality is simply asking for numbers. How many investigators and/or field operators, do you have?

Mr. LOWE. In the Office of Investigations, that is field agents, the equivalent of the police officer, we have 103, I believe, for the country.

Mr. BIAGGI. How many in the New York area?

Mr. LOWE. Fourteen, and that covers four States.

Mr. BIAGGI. How many do you have in the Los Angeles area when the investigation was going on?

Mr. LOWE. I believe we had six.

Mr. BIAGGI. Apparently you worked effectively with the FBI. Mr. Mullen's testimony was revealing. It also highlighted the inadequacy of the system.

The question then that we must consider is how do we deal with that, that is a very real concern.

The only question I can put to you really, because we know the nature of your problem, is what suggestions does HEW have and what will they do in connection with establishing definitions and guidelines that are strict, at least in connection with the definition of a visit. Given that particular situation I am sure there is a host of other areas you are addressing.

Mr. LOWE. Mr. Biaggi, I would like to indicate to you the recommendations which my office has made to the program officials in terms of what we feel is needed in the way of legislative proposals and regulatory proposals. These, we feel, would assist in controlling the abusive practices in the medicare and medicaid programs.

We have made recommendations to amend the statutes, to allow the Secretary to make agreements, including exclusive supplier agreements, and to negotiate payment rates with suppliers of laboratory services, durable medical equipment, and other medical equipment and supplies. This proposal has been transmitted to Congress as part of the administration's medicare/medicaid amendments of 1980, and is estimated to result in cost savings of over $100 million by 1985.

We also recommended that the Department seek legislation to prevent independent laboratories from charging fees to the medicare and medicaid programs which exceed their charges to physicians. This requirement will be unnecessary if the proposal above becomes law. This was pointed out in 1976. We found it in terms of our examination in the clinical laboratory area, and I believe Mr. Mullen found it also, but to a lesser extent because he was not looking at program requirements. This requirement would be unnecessary, however, if the first recommendation is passed.

Mr. Mullen touched upon it in terms of eliminating the competition. If we could control the number and types of laboratories which have access to physicians, et cetera, then we can control the proliferation of competition in rebates and kickbacks and hopefully eliminate that process.

Mr. BIAGGI. These are all individual corporations, right?

Mr. LOWE. Yes.

Mr. BIAGGI. How do you control them?

Mr. LOWE. If we open it up to competitive bidding, and the Secretary has the contractual rights to deal with particular laboratories, we can select the laboratories. As Mr. Mullen indicated, there are a significant number of laboratories run by honest people; unfortunately, things like this give an entire profession a black name. We feel we would have an opportunity to seek out those with good track records and open it up to competitive bidding to get our business. Right now we have no control of it.

Third, we have made a recommendation to amend statutory language to clarify the provisions of current law establishing penalties for bribery of officials administering the medicare program (including employees and agents of State governments and of carriers and fiscal intermediaries) and for bribery by or on behalf of providers and others furnishing items and services under title XVIII. The courts have determined that, if there was an intermediary between the medicare program and the deliverer of the service and he or she was responsible for the offering or administering of the bribe, we could not touch the responsible people because the legislation in terms of bribery did not speak to or address itself to intermediaries.

Finally, we recommended a statute to establish incentive arrangements for special financing to meet individual State needs for management information systems. This also resulted in legislation introduced in the current Congress.

The significant point to be aware of is the fact that most of what Mr. Mullen has pointed out and indeed the congressional report submitted 4 years ago deals with specific abuses in the medicaid program. But the medicaid program is State-administered and I view my ability to accomplish success on the Federal level by assisting the States in looking at their own operations. The Federal Government cannot do everything, we all know that. We do not have the resources, we have 50 States out there. If we assist the States in developing methods, if we assist the States in financing their operations as we do with the medicaid fraud control units, then you will find ultimately once the experience is developed the curve will drop down.

Mr. BIAGGI. On that point, how do you contemplate assisting the States financially?

I will tell you what I have in mind. A man for whom we have great respect for, Mr. Hynes, his agency is threatened with elimination, will your moneys come in?

Mr. LOWE. Let me speak to that. A number of indictments were recently obtained by Deputy Attorney General Hynes. It was 72 indictments, which was quite impressive. I am aware of the fact that the State legislature has cut Mr. Hynes' budget. Mr. Hynes has called my office, as a matter of fact, and has elicited our

support. We do not want to become unduly involved in the State's operation, but there is a point to be made here. We fund Mr. Hynes' operation up to 90 percent. They have cut the budget by $700,000, although New York State's part of the cut is, in effect, $70,000. That is not a significant amount of money. Yet if New York State cuts its budget by $70,000, Mr. Hynes' budget gets cut by $700,000, because it is a matching situation.

Mr. BIAGGI. I understand also they are threatening to transfer his unit into the Attorney General's office, which is a much more serious problem.

Mr. LOWE. We strongly urge and advise in the establishment of these offices independence—that is, a separate unit, independent from any other State office. The reasons are obvious. I would only hope that the structure and status of his office would remain the same as it presently is.

Mr. BIAGGI. Thank you.

Mr. PEPPER. Mr. Lowe, I understand from your previous report, which the staff has examined, that your office does not have authority to impose action like indicting or taking action as to the criminal offender. Is that correct?

Mr. LOWE. We have investigative capacity. We are an investigative office, but we do not have what is known as law enforcement authority. We do not have the power of arrest, the power to issue and execute search warrants. There have been times when my investigators have found this to be an inhibiting factor. But it is our obligation to turn over any examples or any developments or violations of criminal laws to the Department of Justice or the various U.S. attorneys' offices throughout the country. I might add, we work very closely with the Department of Justice and the U.S. attorneys around the country.

As a matter of fact, they have, towards the point I spoke of earlier, as to the attention to white-collar crime, the Justice Department is in the process of establishing economic crime units in each of their regional U.S. attorney's offices around the country. We have direct liaison with those offices.

Mr. PEPPER. Have you been working in close accord with the investigations being made by the FBI?

Mr. LOWE. Yes, sir, we have participated in that investigation. All my staff, especially the audit agency in this particular case, worked closely with the FBI whenever they asked our assistance. We were of the initial opinion we might participate in a joint investigation in this instance. That did not bear fruition. We did not have the finances at that time. I think I will have them in the 1981 budget, and Mr. Mullen and I have been in prospect of joint cooperation. Our audit agency has the program expertise in addition to the audit capability.

Mr. PEPPER. It seems to me you would be able to shorten their investigation by giving them a lot of leads.

Mr. LOWE. I should point out, Mr. Chairman, that I am also very proud of my own investigative staff. You know, we have very capable investigators. I just want to point out that one thing that has become very apparent is that no one can do it alone. We must all pool our resources. To the extent the FBI needs our assistance

and cooperation, we give it to them; to the extent our investigators need their cooperation, the FBI has supplied that.

Mr. PEPPER. What does the Department of Health and Human Services do when you report back to them that you have found kickbacks or you have found fraudulent claims, and so on? What does your department do about it? Does it cut off those people from participating in the program?

Mr. LOWE. The Health Care Financing Administration has authority and exercises that authority to suspend violators from participating in the medicare and medicaid programs. Those providers who have been found guilty——

Mr. PEPPER. Do you have to wait until they are convicted in a court?

Mr. LOWE. They can be suspended when they are under investigation, but the provider then simply gets a show-cause order in court because, in effect, he argues in court, "I am under investigation, I have not been proven guilty of anything, you therefore cannot deprive me of the ability to make a living," and they have been successful. In addition, in the particular area of which you speak and which you are addressing today—that is, the proliferation of kickbacks—as recently as 1979, the U.S. court of appeals, in a decision known as *Porter*, found the exact examples pointed out in 1976 and this morning not to be kickbacks. We have a case in which the physician and laboratory operators were arrested for this process of rebating, they called it rebate as opposed to kickback. The *Porter* decision did impede the investigation into kickbacks until legislation was passed specifically defining kickbacks as any process of remuneration or agreement between two parties.

The court had previously taken the position that a kickback is traditionally known as a person who is the initiator of an amount of money getting back a portion of that same money. Well, as has been pointed out many times, the kickbacks in the clinical laboratories can take a myriad of perspectives ranging from the clinical laboratory paying for a doctor's nurse or paying his rent or cash kickbacks. So, now that has been clarified, but the courts very often pose problems for us.

Mr. PEPPER. Under the new clarification are you getting more effective enforcement against the kickbacks?

Mr. LOWE. To be very candid with you, Mr. Chairman, I have to point out, the kickback area is a very, very difficult area to establish in a court of law. Let me just take a brief moment to explain. I happen to be a former prosecutor in the New York district attorney's office.

We have the authority to require any provider under the medicare or medicaid program to submit to us certain of their books and records. But that has to do with their billings to the Government. We can do that with the laboratories. But in order to document and lay out clearly a sophisticated financial scheme between the parties, we need their entire financial records. We have no such authority to do that. Indeed the difficulty does not end once you do get them, as was pointed out by Mr. Mullen's testimony. I believe he stated that he had a member of a clinical laboratory who pled guilty. They got his books and records pursuant to a grand jury subpena, and they cannot figure out, the Department of

Justice and FBI cannot figure out from those records, the scheme, the documented scheme that was used in the kickback situation.

It just goes to show it can be very sophisticated and can be very difficult to document.

I am not saying that therefore our efforts in that area should not be aggressive. What I am saying is this, with the development of computer screens and a process of examining the programs, you then reduce the availability of opportunity for these people to develop methods to rip off clients.

Mr. PEPPER. If the laboratory claims they have given a rebate to a doctor if he sends them a large number of cases, would they not have to show they have given the same rebate to every other doctor who has referred cases to them?

Mr. LOWE. The first problem would be having the laboratory admit they gave a rebate. Under the present regulations, anytime payment or services——

Mr. PEPPER. Do they not have fixed fees and amortized fees for these services, or are they so nebulous——

Mr. LOWE. We also are supporting regulations which prohibit the billing of medicaid and medicare higher than the billings of private physicians. It was pointed out in the 1976 committee report that this is violative of the medicare and medicaid regulations. I brought this up this morning with counsel. There is no such prohibitive authority in the medicare/medicaid regulations which prohibit the billing of a medicaid patient or physician higher than you would bill a private physician. We have made that recommendation also and we feel and assume that will be of great assistance.

Mr. PEPPER. I can see this is a complex subject. From your experience, what do you recommend that the Congress do to improve your agency or to diminish this prevalent practice of fraud, whether it be kickbacks or overcharging or wrongful billing or whatever? We must diminish the ripoff of funds which are intended to be used to help those who need medical help.

Mr. LOWE. From the congressional perspective I would urge acting on the legislative recommendations in my testimony.

From the Department's point of view, continued close attention by the program officials to the regulatory process of those programs. I just want to say that we in the Inspector General's office have a multidisciplined organization, we have investigators, auditors, and a third group, a very significant aspect of my office, and that is a systems review group. We have doctors, systems people, professionals who look and examine the very programs which we are administering. They examine those programs, then make recommendations to the program people as to how they can better tighten up the process.

I really believe the solution is in the elimination of administrative waste and administrative mispractices, as opposed to complete, total attention toward the criminal process.

It is my firm belief, based on my previous experience, there is a certain element in the society that will never be deterred, but if we can deter the borderline people and convict the offenders in the society with the highest quality in education, opportunity, and finances, the court system must make examples of these people. They must impose strong and stiff penalties. Because if one doctor

in Chicago reads about another doctor sentenced to a few years in jail and he considered overbilling medicaid, maybe he might say it is not worth it.

Mr. PEPPER. I understand you have a large backlog of audits. Why is this?

Mr. LOWE. We have a backlog of audit resolutions. The audit agency audits the grantees we are responsible for auditing, and they submit the results to program officials. The program officials negotiate with the audit people and agree on a dollar figure. There is a process then which involves the return of those dollars to the Federal coffers. It is the resolution of our audit findings by the program officials, which is the holdup.

Mr. PEPPER. Mr. Lowe, we in this Congress, especially in this committee, are trying in every way we can to make more money available for the elderly people of this country to allow them to receive better health care than they are now receiving. We often use the figure that the medicare program pays only about 40 percent of the health care costs of the elderly people of this country. That means they have to pay—if the law is observed, they have to pay $180 to get into a hospital. They have to pay so much out of pocket if they enter beyond a certain time in their life. Then these certain unscrupulous insurance companies come along with insidious agents and rip off the patients by telling them if they have a heart attack or a serious illness, they would not have the money to pay the costs. So they rip them off by selling coverage they do not need.

So we have amendments coming out of the Ways and Means Committee and also out of the Interstate and Foreign Commerce Committee proposing several improvements in medicare. For example, we would eliminate the 100 visits condition, the maximum in the law now, eliminate the $60 deductible they have to pay under the present law, and so on.

Every time we try to provide more medical care for the elderly, we find we do not have the money. Yet apparently, as the FBI tells us, there are millions and millions of dollars which are being stolen by fraudulent, corrupt acts on the part of people working, supposedly to provide medical care to the sick, poor, and elderly.

I hope your agency is as tough as the law allows them to be in this area. Find the ones you are convinced are ripping off the funds of the program. Let them sue, pay a lawyer and go to court, cut them off, put your fist in their face as often and as hard as you can.

Do you think you have a real determined program in your agency to find these ripoff artists and help bring them to justice?

Mr. LOWE. You have my assurance of that, Mr. Chairman. You have my personal commitment, and I know I can speak for Secretary Harris, she is fully committed to the concept of the Inspector General Act and has given me complete cooperation. I give you my personal assurance of that.

I would like to just say this. I believe we will see progress in this area. The development of investigative, audit, and prosecutive expertise, as Mr. Mullen pointed out to me in a personal conversation outside, it takes a little time, but I agree we cannot wait too long. He pointed out the widespread proliferation of skyjacking that

occurred several years ago as an example. Every other day a hijacking occurred. We did not know how to handle it, but with a little time and development of some expertise we learned. Now, except for today's occurrence, you hear very little of rampant skyjackings. Every now and then you have one or two, but it has been a problem that is almost eliminated.

I do not think we will have the quick, successful results as the Bureau did with skyjacking——

Mr. PEPPER. It will take a multi-front approach. The FBI is already alerted to the problem. They have 59 offices around the country. I was chairman of the Crime Committee of the House for 4 years and I know something about this problem and a little bit about the latitude of it. Perhaps the Secretary could call upon the AMA, the American Pharmaceutical Association, the laboratory association, and ask their help, telling them that too much money is being lost, too much smoke is present indicating some of your members are defrauding medicare. You could tell them your own future and reputation is being impaired. If medicare stays in motion and does well it's in everyone's interest but Congress at any time can cut back. If they have any regard at all for ethics they ought to be helping you with it and not trying to steal a coin from the eye of every corpse they can.

You or people in your employ ought to make speeches in communities before senior citizen organizations, ask them to be on the alert, report anything that looks suspicious to them that may come to their attention. Speak to the better business bureaus in the various cities and the chamber of commerce and try to get to the newspapers to say all over the country there is a tragic volume of fraud and corruption that is being perpetrated. We need your help to stop it so we can give more aid to the elderly of this country.

Mr. LOWE. I think that is an excellent suggestion.

Mr. PEPPER. Thank you very much, Mr. Lowe. We appreciate your coming today and the valuable help you have given us. We would like to keep in touch with you. We will ask our staff to keep in touch with you. If there is anything in the way of legislation you think you need or anything we can do, please let us know. We are anxious to help.

[Whereupon, at 1:05 p.m., the hearing was adjourned.]

APPENDIX

AUGUST 25, 1980.

Hon. WILLIAM WEBSTER,
Director, Federal Bureau of Investigation,
J. Edgar Hoover Building, Washington, D.C.

DEAR JUDGE WEBSTER: Your attention to a matter of some importance to the Members of the House Select Committee on Aging would be deeply appreciated.

On May 15 last, our Committee was privileged to have the testimony of Mr. Francis Mullen, Assistant Director of the Criminal Investigative Division and of Mr. Joseph Henehan, Chief of the White Collar Crime Division. We were informed in detail about the FBI's involvement in the investigation of Medicare and Medicaid fraud. I would like to commend you, the men who testified and all of your agents in the field for what you have done in this area. Messrs. Mullen and Henehan were most articulate. They are excellent representatives for the FBI.

During the questioning which took place following Mr. Mullen's prepared statement, Committee Members asked for certain statistics which it was agreed would be furnished for the record.

It may be just an oversight that we have not received the information or perhaps the statistics were sent but have been misplaced, nevertheless, we would appreciate your supplying the following information for the record:

1. Mr. Mullen indicated the FBI had 684 cases of potential Medicare/Medicaid fraud pending as of March 31, 1980. How many cases were pending as of June 30, 1980?

2. Please provide us with a breakdown showing these cases by types of providers. In other words, how many related to clinical labs, how many to hospitals, home health agencies, physicians.

3. Can you provide us with the number of cases pending in each State?

4. How many of the 684 cases were not self-initiated? Conversely, what number were as a result of referrals to the FBI by other agencies?

5. Can you provide us with some breakdown of the cases which began with referrals to you?

(a) How many were developed as a result of referrals from State Medicaid fraud units?

(b) How many were referred by other units of State or local government?

(c) How many were the result of referrals from the Postal Service?

(d) How many were the result of referrals from the Internal Revenue Service?

(e) How many were the result of referrals from the HHS Inspector General's Office?

(f) How many were the result of referrals from other Federal agencies?

6. Approximately how many agents has the FBI allocated to Medicare and Medicaid fraud? And how many man years of labor were expended in these efforts in each of the last two years?

7. What can you tell us about the results of these investigations to date, beyond the impressive number of cases which are pending? How many indictments are the result of FBI efforts? How many convictions? How much in fraudulent payments has been identified? How much has been recovered?

8. With respect to the Bureau's California investigation, which has resulted in about 200 cases to date as we understand it, how many of these cases were as a result of referrals from the Department of Health and Human Services? Finally, do you have any ballpark figure on what the California investigation cost the FBI exclusive of salaries to agents? I have the impression that it was a very cost effective operation.

We would appreciate an early response to these questions. Once again, please let me commend you and the FBI for your good work.

Kindest regards, and

Believe me,

Always sincerely,

CLAUDE PEPPER, *Chairman.*

U.S. DEPARTMENT OF JUSTICE,
FEDERAL BUREAU OF INVESTIGATION,
Washington, D.C., September 26, 1980.

HON. CLAUDE D. PEPPER,
Chairman, Select Committee on Aging,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Reference is made to your letter, dated August 25, 1980, in which you request specific information relative to the Federal Bureau of Investigation's (FBI) involvement in Medicare/Medicaid fraud investigations. Your kind remarks concerning our investigations of Medicare/Medicaid fraud, as well as, FBI representatives who recently testified before the U.S. House of Representatives Select Committee on Aging, are appreciated. You can be assured of our continuing interest and vigorous efforts in investigating these matters.

The information provided below, in response to your specific questions, is set forth in a format which corresponds with the numerical sequence outlined in your letter. Unfortunately, the FBI's information retrieval system is not programed to provide exact answers to all of your questions. In these instances, where possible, an attempt has been made to answer with the information available to us.

1. Mr. Mullen, during his testimony of May 15, 1980, indicated that the FBI had 684 cases of potential Medicare/Medicaid fraud pending, as of March 31, 1980. As of June 30, 1980, this total is 667 pending cases.

2. We are unable to provide a breakdown showing these cases by types of providers (clinical labs, hospitals, home health agencies, physicians).

3. Although we are unable to provide the number of cases pending in each state, the following schedule provides the breakdown, by FBI Field Division, of cases pending and cases closed for Fiscal Year 1980, as of March 31, 1980:

BREAKDOWN, BY FBI FIELD DIVISION, OF CASES PENDING AND CASES CLOSED FOR FISCAL YEAR 1980, AS OF MAR. 31, 1980

FBI field division	Cases pending	Cases closed
Albany	1	5
Albuquerque	4	4
Alexandria	0	9
Anchorage	1	2
Atlanta	2	4
Baltimore	59	5
Birmingham	2	5
Boston	5	7
Buffalo	48	14
Butte	7	0
Charlotte	1	3
Chicago	74	56
Cincinnati	15	5
Cleveland	23	14
Columbia	3	2
Dallas	9	2
Denver	0	3
Detroit	77	64
El Paso	1	0
Honolulu	0	0
Houston	4	1
Indianapolis	5	8
Jackson	7	12
Jacksonville	0	5
Kansas City	9	13
Knoxville	0	1
Las Vegas	0	2
Little Rock	3	5
Los Angeles	66	18
Louisville	3	11
Memphis	5	2
Miami	4	5
Milwaukee	5	1
Minneapolis	11	5
Mobile	2	6

BREAKDOWN, BY FBI FIELD DIVISION, OF CASES PENDING AND CASES CLOSED FOR FISCAL YEAR 1980, AS OF MAR. 31, 1980—Continued

FBI field division	Cases pending	Cases closed
Newark	14	16
New Haven	15	10
New Orleans	22	4
New York City	37	16
Norfolk	2	0
Oklahoma City	16	16
Omaha	11	15
Philadelphia	8	2
Phoenix	6	2
Pittsburgh	13	5
Portland	5	6
Richmond	2	1
Sacramento	6	4
Saint Louis	2	2
Salt Lake City	7	1
San Antonio	6	4
San Diego	3	2
San Francisco	11	18
San Juan	5	0
Savannah	0	1
Seattle	4	9
Springfield	10	5
Tampa	3	3
Washington field	20	14
Total	684	475

4. and 5. The FBI is unable to determine, absent a case by case review, the number of Medicare/Medicaid fraud matters which were self-initiated as opposed to those referred by State Medicaid Fraud Units, other units of state and local government, U.S. Postal Service, Internal Revenue Service, the Office of the Health and Human Services (HHS) Inspector General, and other Federal agencies, as no records are kept in this regard. FBI Headquarters' Officials responsible for overall supervision of Medicare/Medicaid matters are of the opinion that by far the greatest majority of these cases are self-initiated or developed through allegations made by professionals within the industry, citizen complaints and confidential sources. Few, if any, referrals are being received from the Office of the HHS Inspector General.

6. The FBI is unable to provide the number of Agents or man-years allocated or expended in Medicare and Medicaid fraud investigation, without an extensive record review. Our Resource Management Information System is not programed to provide this specific information.

7. FBI investigations of Medicare/Medicaid matters during Fiscal Year 1980, have, as of June 30, 1980, resulted in 112 indictments, 89 convictions, and the recovery of $549,375.00 in cash and/or other assets. These investigations also prevented additional losses to the Government in the amount of $961,183.00. No record is maintained of how much in fraudulent payments these investigations identified.

8. Of the 200 "California investigations" referred to in your letter, none were the results of referrals from the Department of Health and Human Services. The "California investigation," code named Medifraud, was operated at a cost of $51,195.81, exclusive of salaries of FBI personnel.

Hopefully the information provided herein will be helpful to you and the members of your committee.

Sincerely yours,

WILLIAM H. WEBSTER, *Director.*

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